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DRAFT

1. Increase public awareness, engagement and education about dementia.

Strategy	Recommendations (needed policies or responses)
<p>A. Facilitate increased diagnosis and accessing of services. Or, Promote early detection and diagnosis.</p>	<ol style="list-style-type: none"> 1. Educate the public about the importance of and proven advantages - for PWDs, their families, and the state - of getting an [early] diagnosis, including the benefit of early legal and financial planning by collaborating with groups like the Alzheimer's Association and the Alzheimer's Society. 2. Create an evidence-based and culturally appropriate marketing and outreach plan to increase consumer demand for early detection and diagnosis. 3. Assure individuals and community partners know what to ask their health provider about cognitive screening, diagnosis, treatment, and follow-up referrals. 4. Address the critical needs of PWDs who don't have immediate support networks/care partners. 5. Educate consumers to ask for an annual Medicare wellness visit with their healthcare provider, to include a dementia screen.
<p>B. Reverse/reduce stigma surrounding dementia.</p>	<ol style="list-style-type: none"> 1. Promote positive images and messages of persons with dementia and their carers. 2. Provide stigma free places (e.g. Alzheimer's Café's).
<p>C. Create a sense of hope and empowerment for people with dementia.</p>	<ol style="list-style-type: none"> 1. Affirm and support groups already promoting positive images and messages about PWDs, like Momentia, and determine where gaps exist. 2. Request governor's office to host a kick-off event for the Alzheimer's plan. (DSHS/Governor's Office) 3. Promote/host an annual statewide dementia summit. 4. Educate consumers about ways to protect those with dementia from abuse through public service announcements. 5. Coordinate with Family Caregiver Program to identify special issues facing caregivers of people with dementia, and provide information and assistance tailored to the needs of caregivers of people with dementia. 6. Identify issues specific to younger-onset PWDs and their families.

	<ol style="list-style-type: none"> 7. Offer materials and information to underserved populations, including rural populations; assure material on dementia is multi-cultural, multi-lingual, appropriate for persons with sensory limits (e.g. vision and hearing loss), and tailored to state demographics. 8. Promote outreach to Indian Country through health workers, tribal communications and health fairs. 9. Provide special outreach to those with Down Syndrome and their families. (DSHS/DDD) 10. Promote internationally recognized dementia friendly principles (e.g. http://www.bupa.com/media/global-dementia-charter-english-final.pdf) as models for support for persons with dementia. Build connections with communities such as faith communities, service organizations, Kiwanis, Rotaries, organized women's groups, etc. to help identify, empower, and assist communities to become dementia-friendly. Utilize information (toolkits etc.) from other states. Look at Minnesota "Dementia-Friendly Toolkit". 11. Create greater sensitivity of business, faith community, and service organizations staff to respond to the person with dementia with respect and dignity.
D. Ensure statewide coordination of information and referral.	<ol style="list-style-type: none"> 1. Develop, launch and oversee a single web-based "point-of-access" portal/website to a comprehensive statewide array of information, resources and supports. 2. Promote/raise awareness of where to go for help and information. Publicize and promote the point-of-access portal. 3. Promote "dementia navigators" who can provide support, information and guidance to PWD's and their carers. 4. Provide Alzheimer's awareness, education and resource materials to public/private work places regarding how to recognize and relate to persons with early dementia or their carers who are their customers or employees. 5. Use social media to increase public awareness of sources for information and education about Alzheimer's and dementia. Messages will direct the public to the Alzheimer's Association Chapters, Alzheimer's Society of Washington, and AAA/Community Living Connections.
E. Identify and utilize reliable and evidence-based information on Alzheimer's disease	<ol style="list-style-type: none"> 1. Promote components of education to carers, health care professionals, first responders, state employees and communities of faith (An example of a fact sheet-10 signs of Alzheimer's Disease-How it Differs from Normal Aging http://secondnature.com/free-resources-a/) 2. Partner with Office of Superintendent of Public Instruction and local school districts to advance primary and secondary

and other dementias.	curriculum development regarding brain health and dementia (e.g., in general health classes).
F. Promote advance care planning and advance financial planning in the early stages of dementia before function declines.	<ol style="list-style-type: none"> 1. Provide state-approved forms specifically designed to be applicable for those with dementia such as Durable Power of Attorney for Finances, Advanced Directives, information about a Physical Order for Life Sustaining Treatment (POLST) to be made available at no cost to consumers through public libraries, resource center, online and other appropriate locations. 2. Disseminate information on and provide education about the need for advance care and end-of-life planning for consumers, utilizing existing resources such as the Conversation Project. Include references to sample documents including state approved forms with instructions and to those provided by advocacy groups such as 5 Wishes, Compassion and Choices, and Honoring Choices. 3. Encourage all health care systems to create standards of care for advance care planning and end of life care for persons with dementia. 4. Encourage licensed long term care facilities to have relationships with one or more hospices to provide education and end of life care to assure residents can stay in place through the end of life.
G. Promote collaboration and coordination among the private and public sector to increase awareness.	<ol style="list-style-type: none"> 1. Engage public and private champions (e.g. corporations, celebrities, faith community leaders) in a public relations campaign to raise awareness of dementia and available resources. 2. As people more readily accept messages from people they trust, utilize faith- based organizations and physicians/health care providers to help get the awareness message out. 3. Promote and raise awareness of where to go for help and information including a toll-free number and statewide Alzheimer's network. 4. Build links between public/private organizations such as the Alzheimer's Association, the Alzheimer's Society and Area Agencies on Aging and other partners in order to strengthen dementia capable service information systems. 5. Engage parties (e.g. chamber of commerce, community college and university students) who are not part of the traditional information service system who can play a vital role in promoting a safety net.
H. (Incorporate and emphasize these philosophical principles into	<ol style="list-style-type: none"> 1. Capture the "Nothing About Us Without Us" philosophy. 2. Affirm the gifts of and contributions of persons with dementia.

narrative form somewhere in the report, remove from recommendations because these are difficult to reduce to a S.M.A.R.T. recommendation.)	<ol style="list-style-type: none"> 3. Emphasize the comprehensive spectrum of persons with dementia from younger persons to end of life. 4. Expand understanding of the PWD – don't let the disease define them; treat with dignity and respect. 5. Build awareness of groups who have English as a second language 6. Have services and supports available for the duration of the life of the PWD. 7. Promote dementia-friendly models across communities. 8. Provide a way to get “bite size” pieces of information about best practices into the hands of the public and providers. 9. Define dementia-friendly principles.
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2. Advance public health strategies for dementia

Strategy	Recommendations (needed policies or responses)
A. Attain, analyze, and use available data to inform statewide planning.	<ol style="list-style-type: none"> 1. DOH will request and receive resources to obtain meaningful data from the Behavioral Risk Factor Surveillance Survey (BRFSS) cognitive and caregiver modules. Meaningful data would include sample sizes large enough to establish statewide estimates, which may require oversampling. 2. Partners will provide leadership in using BRFSS data to understand the human and economic impact of dementia on individuals and family caregivers to inform public health policies, interventions, and development of the <u>Washington State Plan for Healthy Communities</u> state plan and any specific chronic disease plans.
B. Integrate Alzheimer's and dementia into state and local government plans.	<ol style="list-style-type: none"> 1. State and local governments will integrate memory loss and dementia into strategic plans (e.g. aging, coordinated chronic disease, falls prevention, emergency preparedness, and transportation plans). 2. DOH will incorporate cognitive health/impairment and dementia into ongoing activities focused on injury prevention, falls prevention, and emergency preparedness.

	<p>3. Integrate Healthy People 2020 objectives on Persons with Alzheimer’s and dementia in state strategic plans. This includes increasing the proportion of persons with diagnosed Alzheimer’s disease and other dementias that are aware of the diagnosis. Reduce the proportion of preventable hospitalizations in persons with diagnosed Alzheimer’s disease and other dementias.</p>
C. Promote brain health.	<p>1. Partner with UW Healthy Brain Research Network (HBRN) and ADWG partners to develop evidence-based messages and communication campaign about risk reduction and preserving brain/cognitive health, designed to reach statewide populations including limited English proficiency and ethnic populations.</p> <p>2. Partner with HBRN and other community partners to disseminate evidence-based educational materials for the public around risk reduction strategies and how to use health care proactively.</p> <p>3. Promote and build upon national Alzheimer’s Plan education and awareness campaigns as available i.e., National Plan and Centers for Disease Control campaigns such as “Brain Health As You Age: You Can Make a Difference”.</p> <p>4. Request that all public health entities provide content specific to aging, brain health, and Alzheimer’s disease/dementia, including links on their websites to national, state and local resources.</p> <p>5. Promote implementation of evidence-based health promotion programs such as Reducing Disability in Alzheimer’s Disease (RDAD), Chronic Disease Self-Management Program (CDSMP), Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), and STAR-C dementia behavior consultation for people with dementia and caregiver.</p>

3. Ensure well-being and safety of people living with dementia and their family caregivers

Strategy	Recommendations (needed policies or responses)
A. Increase awareness to reduce the risk for neglect, abuse, and exploitation of people with memory loss.	<ol style="list-style-type: none"> DOH will incorporate content about dementia (warning signs, the importance of early detection and diagnosis), the heightened risk of abuse, neglect, and exploitation; and about community resources into the Community Health Worker training. Update and request funding to expand and implement the Gatekeeper Program through Area Agencies on Aging (AAAs) or aging service partners to aid in identifying and assisting people experiencing abuse, neglect or exploitation.
B. Enhance legal protections for people living with dementia to protect against abuse and neglect.	<ol style="list-style-type: none"> Convene a workgroup to review and improve criminal laws related to neglect, abuse and exploitation of vulnerable adults. Make available state-approved forms such as Durable Power of Attorney for Healthcare, Durable Power of Attorney for Finances, Advanced Directives, and information about a Physical Order for Life Sustaining Treatment (POLST) at no cost to consumers through public libraries, resource centers, online, and other appropriate locations. Ensure wishes of individuals are known and respected and avoid costly court proceedings by: <ol style="list-style-type: none"> Encouraging financial planning for those with cognitive impairment and dementia and their families – with the assistance of an experienced attorney, if possible. Encouraging use of Powers of Attorney, POLSTs, Advance Directives – with the assistance of their physician and if possible, an experienced attorney. Encouraging individuals and caregivers to learn about financial and legal impact of dementia and importance of obtaining legal and financial advice as a planning tool. Encouraging individuals and caregivers to learn about and actively engage in discussion surrounding end of life issues. Convene a workgroup to evaluate current statute and regulations that affect people with dementia, specifically those regarding powers of attorney, guardianship, trusts and wills to: <ol style="list-style-type: none"> Decrease fraud, abuse, neglect and self-neglect and the enrichment of wrongdoers through undue influence. Maximize autonomy and independence of individuals with dementia. Create and provide voluntary training regarding dementia and make available to all legal guardians. Increase awareness about and encourage the use of multi-disciplinary teams to address issues with vulnerable adults, including those with dementia.

	<ol style="list-style-type: none"> 6. Adult Protective Services (APS) will work toward establishing Elder Justice Centers statewide to ensure coordinated efforts and improved communication with law enforcement, APS, local prosecuting attorney's offices, and advocacy groups. 7. Explore screening tools that may be used by APS, law enforcement, and other entities to identify diminished capacity and cognitive impairment. 8. Promote existing and emerging opportunities to educate financial institution staff about dementia and possible financial exploitation and abuse, their authority to report suspected abuse, and the protections for those who report e.g., "Spotting Financial Exploitation" from the Attorney General's Office.
C. Promote practices to ensure driving safety of individuals with memory loss and/or dementia.	<ol style="list-style-type: none"> 1. Convene a workgroup, to include representative of the Department of Licensing, to evaluate policies and best practices for promoting safe driving in people with dementia. 2. Encourage and promote establishment of Driver Assessment programs (by Occupational Therapists with expertise in dementia) at hospitals, diagnostic assessment centers and major rehab centers. 3. Promote the provision of Safe Driving Evaluations through private pay and insurance, Public Employee Benefits Board and other public benefits. 4. DSHS will develop toolkit to educate families about ways to discuss and address driving issues, including how to work with the Department of Licensing.
D. Promote in-home safety and the quick return of people with dementia who may wander.	<ol style="list-style-type: none"> 1. DSHS and partners will compile and make accessible educational materials for caregivers about ways to improve safety for people with dementia such as falls prevention, wandering and disaster preparedness, to include information about home safety assessments. 2. DSHS and partners will disseminate and promote awareness of programs designed to identify and locate people with dementia who may wander e.g., Safe Return and Comfort Zone, to health care providers, organizations, and families. 3. Support the creation (or enhancement) of a statewide system to alert authorities and the public when a person with dementia is lost or in danger. 4. Promote and disseminate training for first responders about dementia, to include: recognizing signs and symptoms, communication skills, understanding behaviors including wandering, community resources, and red flags of neglect and abuse.

E. Identify and address other safety risk factors for individuals with dementia.	1. HCA (other?) will use state data regarding prevalence of injuries such as falling, accidents, overmedication, mental health – anxiety, depression, isolation, and other important issues.
F. Raise awareness of primary care workforce around stress and potential negative health consequences for dementia caregivers.	<ol style="list-style-type: none"> 1. Identify and disseminate information on how to identify, assess, and respond to caregiver stress and on how to work with family caregivers to ensure that the complex health and care needs of their care recipients are understood. 2. Make available information for health care teams to understand the intent and differences between, power of attorney, guardianship, and other advanced planning documents. 3. Make available information and continuing education for providers, health care teams to understand how competency is assessed and when it might be indicated to do so.

4. Ensure access to comprehensive supports for family caregivers.

Strategy	Recommendations (needed policies or responses)
A. Increase access to respite.	<ol style="list-style-type: none"> 1. DSHS and partners should promote education and coaching around utilizing natural support networks and care teams to support the person with dementia and the family caregiver. 2. Fund DSHS to expand funding for respite care, and explore flexible service models, such as overnight care, drop-in day care, volunteer-based programs, crisis/emergency respite, and models that promote wellness, e.g., Memory Care & Wellness Services.
B. Provide guidance and support for dementia caregivers in navigating the system.	<ol style="list-style-type: none"> 1. Create a state-specific “road map” for family caregivers, providing information about what to expect over time to help plan for the future. 2. Fund DSHS to expand Options Counseling and TCARE® Assessment and Consultation. 3. Increase awareness of both public and private programs that offer professional guidance, e.g., Options Counseling, Health Homes, private geriatric case managers, Alzheimer’s organizations, etc.

<p>C. Increase availability of and access to education and support services.</p>	<ol style="list-style-type: none"> 1. Fund DSHS to increase availability of evidence-based programs for people with dementia and their family caregivers, e.g. STAR-C, Reducing Disability in Alzheimer’s Disease (RDAD), early stage memory loss groups and Powerful Tools for Caregiving, and expand supportive services such as behavior consultation, counseling, flexible family supports, etc. 2. Increase availability and delivery systems of education for family members about communications skills, understanding and responding to non-verbal cues and behaviors, and home care activities (i.e., assuring home safety, managing medications, using effective approaches for personal care and oral health needs, addressing hearing loss and other sensory deficits, and incorporating physical and meaningful activity into the day).
<p>D. Utilize assistive technologies to promote independence for people with dementia and to support family caregivers.</p>	<ol style="list-style-type: none"> 1. Identify and promote the use of assistive technologies that assist with independence, safety and aging in place. 2. Create a resource guide/toolkit that describes adaptive technologies and equipment relevant for memory loss and dementia.
<p>E. Reach individuals and family members early in disease through collaborative models of social engagement</p>	<ol style="list-style-type: none"> 1. Develop and disseminate information about models of social engagement such as Alzheimer’s Cafes, Zoo Walks, Museum/Arts (“here: now”) programs, etc. 2. Disseminate and promote development of collaborative models throughout the state.
<p>F. Engage diverse family caregivers through culturally and linguistically appropriate supports.</p>	<ol style="list-style-type: none"> 1. Identify leaders and organizations of diverse populations to explore needs for education and support.
<p>G. Develop supports for specific populations including family caregivers who are employed, caring for</p>	<ol style="list-style-type: none"> 1. Educate employers and those responsible for developing and implementing Employee-Assistance Programs about the issues facing family caregivers and encourage them to incorporate policies such as flextime, telecommuting, referral services, and on-site support programs. 2. Inform caregivers and patients about the Family and Medical Leave Act, long-term care insurance, the benefits of advanced legal and financial planning, and existing support programs through agency websites, educational forums,

people with developmental disabilities and dementia, and those living with young-onset Alzheimer's disease.	<p>service networks, and the media.</p> <ol style="list-style-type: none"> 3. Examine need for education and supports for older family caregivers who provide primary care for their adult children or siblings with developmental disabilities and dementia. 4. Assess barriers and best practices for individuals and families living with younger-onset Alzheimer's and develop strategies to enhance support for these families. 5. Educate professionals working with families of people with younger-onset Alzheimer's, including those in the DD system, about the special challenges and issues and resources available to support these individuals. 6. Fund DSHS to increase awareness among the public and community agencies that the Family Caregiver Support Program helps caregivers of people with dementia at any age.
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5. Identify dementia early, and provide dementia-capable health care and support for patients and families/care partners.

Strategy	Recommendations (needed policies or responses)
A. Promote early detection and diagnosis and evidence-based health care.	<ol style="list-style-type: none"> 1. Convene an expert panel to review existing evidence-based practices for early detection, diagnosis, treatment and support for people with cognitive impairment and dementia, and endorse or refine for Washington State, and propose an implementation/spread plan. 2. Create and promote a visible, specific and concrete cognitive impairment/dementia 'vital sign' for use by care teams, similar to tracking blood pressure in heart disease.
B. Increase awareness of the challenges associated with co-occurring conditions with dementia.	<ol style="list-style-type: none"> 1. Identify/manage dementia as a chronic condition. 2. Recognize that dementia often occurs with and can complicate the management of other chronic conditions. Once identified, cognitive impairment and dementia should become an organizing principle for all other care of the patient. 3. Educate and increase awareness of how dementia and having other chronic conditions, as well as poor management of conditions (i.e., poor control of BP and blood sugar with concurrent irritability, mood liability and exacerbation of cognitive symptoms) impacts the individual and care that is provided.

	<ol style="list-style-type: none"> Educate and increase awareness of how dementia and sensory loss such as hearing, vision, balance impacts the individual and care that is provided. Include in training and guidelines information about the importance of assessing and addressing sensory loss and dementia – to include hearing, vision, and balance. Support educational efforts to improve end of life discussions between patients and their providers. Promote initiatives and recommendations for people with worsening dementia (i.e., palliative care recommendations by the Bree Collaborative)
C. Define or adopt an evidence-based dementia care model for Washington State.	<ol style="list-style-type: none"> Convene an expert panel to establish/adopt guidelines for ongoing care for people with dementia in light of the Chronic Care model, determine steps needed to promote change in practice (i.e., create change package) such as Borson/Chodosh2014 dementia care model. – (shorter term goal) Integrate into the Healthier Washington Practice Transformation work. – (longer term goal) (DOH) Integrate a ‘dementia care model’ into existing programs and trainings that target patients with multiple conditions (i.e. Health Homes, Transition Models, collaborative care models).
D. Reduce preventable ED visits, hospitalizations and readmissions by improving communication and transitions of care.	<ol style="list-style-type: none"> Define what Care Coordination and Health Navigation is and where it can be used to improve communication and transitions of care for individuals with dementia. Create guidelines/protocols for care coordinators and health navigators in working with individuals with dementia. Develop new and support existing care coordination efforts (e.g., Health Homes, Home Health visits, SNF transitions of care initiative, WSHA safe table on transitions, Coleman Transitions (CTI), and Qualis Health communities for safe transitions resources) - to improve outcomes related to ED Visits, hospitalizations and readmissions through improved transitions of care from hospital to community (i.e. models such as Indiana University’s Center’s Healthy Aging Brain Center’s team-based collaborative care model) (HCA?) Conduct a community assessment to identify gaps in these services. (DOH?)
E. Improve understanding of and response to	<ol style="list-style-type: none"> Conduct an environmental scan to identify supports and/or trainings in the community for addressing challenging behaviors and to identify gaps/needs.

challenging and/or complex behaviors	<ol style="list-style-type: none"> 2. Create a network of trainers or resources to assist health providers and care teams in effectively responding to individuals with challenging behaviors. 3. Create informational tools for physicians to provide to family caregivers about dementia, understanding behaviors, and resources to help families with behaviors (i.e., , Alzheimer’s Association, Alzheimer’s Reading Room, STAR-C behavior intervention) 4. Convene work group to investigate models of behavior and crisis support that might be replicated across the state (e.g. King County’s Geriatric Regional Assessment Team (GRAT) - funded largely by mental health state levy tax).
F. Research and document the impact of dementia through statewide and county level data.	<ol style="list-style-type: none"> 1. Request Qualis Health data (75% of all individuals with Medicare), state Medicaid data (managed care plans and FFS) and private health providers to identify rates of utilization as impacted by dementia. (HCA?) 2. Conduct an initial and ongoing analysis of the impact of dementia on emergency room visits and hospitalization rates (utilization rates) in WA state and geographic regions, from data above to target interventions/pilots/support. (HCA?) 3. Provide information about dementia and co-occurring conditions back to health providers to provide awareness and education about the impact of dementia and conditions like depression on hospital utilization rates for ambulatory sensitive conditions. (HCA? DOH?)
G. Support development and implementation of dementia related outcomes-based performance measures.	<ol style="list-style-type: none"> 1. Maintain and provide information about the number of patients with cognitive impairment and dementia back to providers so they will know whom they have in their patient panels and how their care, in terms of health maintenance and the management of other chronic conditions, compares to their patients without dementia. (health care systems) 2. Endorse a set of dementia specific performance metrics such as Physician Quality Reporting System (PQRS) endorsed metrics or Association of Neurology recommended metrics (at minimum a measure for clinic-based dementia screening) (HCA?) 3. Endorse a set of appropriate dementia caregiver measures. 4. Promote the inclusion of the endorsed dementia related metrics within existing measurement sets (especially targeting the Healthier Washington Practice Transformation work) (HCA) 5. Recommend to the Washington Health Alliance to include measures on dementia in community checkup report. 6. Increase provider incentives and reimbursement for using evidenced based treatments and outcome tracking.

	<ol style="list-style-type: none"> 7. Recommend individuals with dementia be identified as high risk subpopulations for efforts targeting other relevant conditions (diabetes, cardiovascular disease, and depression).
H. Assure that access to dementia-capable health care extends statewide.	<ol style="list-style-type: none"> 1. Convene an expert panel to define the needed service elements required to provide optimal health care across the state for individuals with dementia i.e., Dementia care specialists; geriatric psych units; geriatricians, dementia specialty facilities/beds, telehealth, specialized dementia centers; diagnostic centers, adult day health, PACE models. 2. Convene a workgroup to conduct a statewide scan to identify and catalogue all existing healthcare service elements, identify gaps in each region or community, and make recommendations. (HCA?) 3. Promote use or identify potential use of tele-health by aligning with the efforts of the state-wide tele-health workgroup, convened by DOH (i.e. collaborative care models like Impact and Echo project): <ol style="list-style-type: none"> a. Directly - to assist in the care of individuals with dementia b. In a consultative role with providers/care teams 4. Coordinate/partner with the Washington Healthcare Improvement Network (WHIN), other practice transformation initiatives (i.e. Healthier Washington) and medical (MD, nursing, PA, ARNP, OD, ND) associations to disseminate evidence-based guidelines and support to care teams. (HCA/DOH?)
I. Develop dementia capable, culturally competent primary care workforce.	<ol style="list-style-type: none"> 1. Create training and examples of how to convey to patients and care partners that the patient has cognitive impairment or dementia. 2. Establish minimum educational requirements for medical providers to obtain competency in dementia care. 3. Mandate training in best practices around dementia and geriatric care for all medical students and for residents in all specialties where doctors routinely provide care to older adults and required to attain competency in the unique approach to care that distinguishes geriatrics as a specialty. 4. Partner with professional organizations and academic settings to develop or increase the availability of continuing education/training programs for practice teams/health systems/care managers/patient navigators/CHW program 5. Partner with licensing boards to mandate continuing education on evidence-based guidelines around early detection and diagnosis of cognitive impairment, dementia care interventions and management of the disease. 6. Advocate loan forgiveness for physicians and physician-extenders going into geriatrics.
J. Support policies that	<ol style="list-style-type: none"> 1. Request and encourage the Bree Collaborative to address the assessment of cognitive impairment and dementia care.

<p>promote the capacity of primary care to adequately screen, diagnose, counsel, and treat patients with cognitive impairment/dementia.</p>	<ol style="list-style-type: none"> 2. Promote value-based reimbursement in primary care with employer groups and public/private health plans. 3. Support development of billing codes and appropriate reimbursement for care that improves the health and lives of older adults (i.e. counseling, phone calls, care coordination etc). 4. Promote understanding and effective utilization of: <ol style="list-style-type: none"> a. Medicare Annual Wellness Visit which includes objective cognitive assessment/screening and snapshot of patient's health risks and current health care arrangement. Elements can be done by non-physicians and provides a better reimbursement rate. b. Promote use of complex care management (CCM) and advanced planning codes. Most patients with dementia have multiple chronic conditions.
<p>K. Leverage data derived from evidence based studies to design and optimize Community and Clinic Dementia care team based systems in Washington state.</p>	<ol style="list-style-type: none"> 1. Create a taskforce charged with a) regularly evaluating success of similar pilots (and identified weaknesses of other projects that can be avoided) b) translating success of community/clinic team approaches in decreasing Medicare/Medicaid costs to present to WA state budget negotiators/legislators. 2. Design the protocol for safety assessments (abuse, home safety, appropriateness of remaining in the home). 3. Determine optimal team members (psychiatry, social work, care coordinators, geriatricians) and the optimal venue/frequency of team care assessments. (Health care systems?) 4. Consider a continuous team approach to dementia care in the community: A team whose members make home visits and conference with clinic social workers, physicians, and therapists regularly. 5. Broaden team's needs assessment of patient and patient's caregiver with regard to education, primary care medical attention, social services, frequency of monitoring (Health care systems?)

6. Ensure affordable, high quality, coordinated long-term services and supports (LTSS) available in the setting of choice.

Strategy	Recommendations (needed policies or responses)
A. Expand access to care.	<ol style="list-style-type: none"> 1. Fund DSHS to support a robust array of community-based services to include adult day care and evidence-based practices such as Memory Care & Wellness, STAR-C, etc. 2. Fund DSHS to provide flexible family support services to sustain more people in their homes and avoid spend-down to Medicaid. 3. Instruct DSHS to undertake a review of Medicaid rates for specialized dementia care in assisted living facilities. 4. Provide funding to evaluate specialized dementia care in adult family homes to determine cost-effectiveness, standards, training, services and rates.
B. Enhance coordination of care.	<ol style="list-style-type: none"> 1. Fund DSHS to provide options counseling for all age groups, including those without family caregivers. 2. Promote models of care coordination for individuals living in the community and their family caregivers (Health Homes, geriatric care managers, Alzheimer's Association Care Navigators) 3. Convene a workgroup to identify and support best practice models of care coordination between physicians, hospitals, and other providers to improve outcomes and minimize hospital readmissions for people with dementia. 4. DDA, ALTA and DOH will each designate an Alzheimer's program coordinator to improve communication and collaboration among these agencies.
C. Strengthen numbers and effectiveness of LTSS workers	<ol style="list-style-type: none"> 1. Ensure training and testing for all LTSS workers is more readily available throughout the state. 2. Focus more hours of the required training towards best practices in dementia care. 3. Ensure certification of all LTSS workers is more achievable for limited English speakers. 4. Increase awareness and availability of dementia training for non-Medicaid funded professionals. 5. DSHS will increase dementia-capability of HCS/AAA Case Management staff by enhancing Core training to include more information around the importance of early detection and diagnosis, responding to behaviors, and assessing and

	<p>addressing hearing loss and other sensory limitations.</p> <ol style="list-style-type: none"> 6. DSHS will enhance Dementia Specialty Training available to LTSS workers for all settings. 7. Enhance appeal of working with people with dementia by establishing a geriatric and/or dementia certification for LTSS workers, such as “gero-scholars” at PLU.
D. Improve the quality of long-term services and supports for people with dementia.	<ol style="list-style-type: none"> 1. Define and enforce quality and outcome measures in all licensed residential care settings. 2. Establish standards for non-Medicaid specialized dementia care settings to enhance consumer education and protections. 3. DSHS will enhance ability of Adult Protective Services to serve people with dementia by strengthening skills and tools for determining capacity and the need for guardianship. 4. The Legislature will more adequately fund the Long Term Care Ombuds Program (LTCOP) to serve vulnerable people in all settings. 5. Promote the documentation of people’s choices for end-of-life care and ensure they are honored. 6. Expand funding and the authority of the Office of Public Guardianship to assist individuals with planning end of life care and decision making.
E. Address financing and cost containment.	<ol style="list-style-type: none"> 1. Support a study commissioned by the State on public/private long-term care financing models. 2. Advocacy groups will support State efforts to improve the financing for public LTSS. 3. Meet the cost of financing care by effective coordination of all current systems and federal funding opportunities. 4. Work toward parity in all health insurance plans in regard to diagnosis and ongoing support/treatment of persons with dementia. 5. Fund DSHS to increase operations research capacity at ALTSA to support data-driven evaluation and planning.

7. Promote research and innovation into the causes and effective interventions for dementia

Strategy	Recommendations (needed policies or responses)
A. Increase support for basic, clinical and translational research around cognitive health, dementia and effective dementia care.	<ol style="list-style-type: none"> 1. Explore ways to improve the research infrastructure for supporting basic, translational, and clinical research in the state and region. 2. Leverage the metrics from health information exchanges as they become available, to support research efforts at the clinic level. 3. UW, DSHS, DOH, HCA will explore funding opportunities and collaborations for Washington to participate in dementia care service innovation programs.
B. Develop relationships with key community stakeholders to assess and pilot culturally specific/relevant services.	<ol style="list-style-type: none"> 1. Identify all organizations and institutions in WA involved in AD research to promote research awareness and strategic alliances.
C. Increase number of research participants.	<ol style="list-style-type: none"> 1. Engage community physicians to encourage patient referral to and participation in clinical trials and provide examples of 'how to have the conversation'. 2. Educate the public, including people with cognitive impairment, on the availability, purpose, and value of research and encourage participation in clinical trials and studies (i.e. Alzheimer's Association Trial Match, the University of Washington Alzheimer's Disease Research Center). 3. ADWG partners to host a collaborative Alzheimer's Summit highlighting research and best practices related to the Alzheimer's State Plan goals (by fall 2016).